Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS SPINE AND JOINT

Respondent Name
TRAVELERS INDEMNITY CO OF CONN

MFDR Tracking Number
M4-17-2990-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JUNE 12, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Hospital's records, the patient's lumbar spine was injured in a work related incident. His last diagnostic test pirot to the above date of service at issue was an MRI in 2015. The enclosed business records dated January 6, 2017 indicate a Hospital representative spoke with the adjuster who verbally approved the MRI. The Hospital then provided the MRI and billed Travelers, but the bill was denied for no authorization."

Amount in Dispute: $6,378.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Provider called the Carrier requesting approval for an MRI. The adjuster, Jeanette Broadway, informed the Provider that the MRI would require preauthorization and provided the preauthorization fax number. The Provider submitted a request for preauthorization the same day. The Carrier reviewd the request and determined the request did not meet medical necessity standards. The Provider was notified verbally of the denial on 01-17-2017, and a denial letter was sent to the Provider the same day."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2017	Outpatient Hospital Services for a repeat MRI	$6,378.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective July 1, 2012,requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 198-Payment denied/reduced for exceeded precertification/authorization.

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 802-Charge for this procedure exceeds the OPPS schedule allowance.
- UM07-Based on the information available at the time of review, the preauthorization for this service appears to have been denied.`

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed hospital outpatient services for a repeat MRI based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(8) requires preauthorization for "unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline. "

The requestor contends that reimbursement is due because "The enclosed business records dated January 6, 2017 indicate a Hospital representative spoke with the adjuster who verbally approved the MRI."

The respondent continues to deny reimbursement for the disputed MRI based upon "the Provider called the Carrier requesting approval for an MRI. The adjuster, Jeanette Broadway, informed the Provider that the MRI would require preauthorization and provided the preauthorization fax number. The Provider submitted a request for preauthorization the same day. The Carrier reviewd the request and determined the request did not meet medical necessity standards. The Provider was notified verbally of the denial on 01-17-2017, and a denial letter was sent to the Provider the same day."

In support of the position, the respondent submitted a copy of the report that supports the denial of preauthorization for the disputed MRI.

Based upon the submitted documentation, the requestor did not obtain preauthorization in accordance with 28 Texas Administrative Code §134.600(p)(8). As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/28/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.